Reprinted
February 9, 1999

# HOUSE BILL No. 1195

DIGEST OF HB 1195 (Updated February 8, 1999 5:52 pm - DI 88)

**Citations Affected:** IC 27-14; IC 34-18; noncode.

**Synopsis:** Health maintenance organization liability. Provides for a duty of ordinary care for health insurance carriers, health maintenance organizations, and other managed care entities when making health care treatment decisions. Makes health insurance carriers, health maintenance organizations, and other managed care entities liable for harm resulting from health care treatment decisions that are made without exercising ordinary care. Prohibits a health insurance carrier, a health maintenance organization, or other managed care entity from removing a health care provider from, or renewing the status of the health care provider with, the health care plan for advocating on behalf of an insured or enrollee for appropriate and medically necessary care. Prohibits contract indemnification or hold harmless clauses from applying to the acts or conduct of health insurance carriers, health maintenance organizations, and other managed care entities. Provides

(Continued next page)

**Effective:** July 1, 1999.



## Pelath, Fry, Adams T, Ulmer

January 11, 1999, read first time and referred to Committee on Insurance, Corporations and Small Business.
January 26, 1999, reported — Do Pass.
February 8, 1999, read second time, amended, ordered engrossed.

Digest Continued

that the amount of the medical malpractice surcharge for a qualified provider other than a licensed physician or hospital may not exceed the actuarial risk posed to the patient's compensation fund by a qualified provider other than a licensed physician or hospital.

Reprinted
February 9, 1999

First Regular Session 111th General Assembly (1999)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 1998 General Assembly.



# HOUSE BILL No. 1195

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

*Be it enacted by the General Assembly of the State of Indiana:*

SECTION 1. IC 27-14 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:

**ARTICLE 14. LIABILITY FOR CERTAIN HEALTH CARE TREATMENT DECISIONS**

**Chapter 1. General Provisions and Definitions**

**Sec. 1. This chapter does not apply to worker's compensation insurance coverage under IC 22-3-2 through IC 22-3-6.**

**Sec. 2. The definitions in this chapter apply throughout this article.**

**Sec. 3. "Enrollee" means the following:**

**(1) With respect to a health maintenance organization, a:**

**(A) subscriber; or**

**(B) dependent of a subscriber;**

**who is covered by the health maintenance organization.**

**(2) With respect to a managed care entity other than a health maintenance organization:**

**(A) an individual who is enrolled in a health care plan; or**

**(B) a dependent of an individual described in clause (A) who is covered by the health care plan.**

**Sec. 4. "Health care plan" means a plan under which a person assumes responsibility to:**

**(1) arrange for;**

**(2) pay for; or**

**(3) reimburse any part of the cost of;**

**health care services through a health insurance carrier, a health maintenance organization, or another managed care entity.**

**Sec. 5. "Health care provider" has the meaning set forth in IC 34-18-2-14.**

**Sec. 6. "Health care treatment decision" means a determination that:**

**(1) is made when medical services are provided by a health care plan; and**

**(2) affects the quality of the diagnosis, care, or treatment provided to an insured or enrollee of the health care plan.**

**Sec. 7. "Health insurance" means one (1) or more of the kinds of insurance described in Class 1(b) and 2(a) of IC 27-1-5-1.**

**Sec. 8. "Health insurance carrier" means an insurer (as defined in IC 27-1-2-3) that provides health insurance.**

**Sec. 9. "Health maintenance organization" has the meaning set forth in IC 27-13-1-19.**

**Sec. 10. (a) "Managed care entity" means an entity that, on behalf of or as part of a health care plan:**

**(1) delivers health care services to a defined enrollee population;**

**(2) administers the delivery of health care services to a defined enrollee population; or**

**(3) assumes the risk for the delivery of health care services to a defined enrollee population.**

**(b) The term does not include:**

**(1) an employer purchasing coverage or acting on behalf of:**

**(A) its employees; or**

**(B) the employees of one (1) or more subsidiaries or corporations affiliated with the employer; or**

**(2) a pharmacy that holds a pharmacy permit issued by the Indiana board of pharmacy under IC 25-26-13.**

**Sec. 11. "Ordinary care" means the following:**

**(1) With respect to:**

**(A) a health insurance carrier;**

**(B) a health maintenance organization; or**

**(C) another managed care entity;**

**the degree of care that a health insurance carrier, health maintenance organization, or managed care entity of ordinary prudence would use under the same or similar circumstances.**

**(2) With respect to a person who is an employee, an agent, an ostensible agent, or a representative of:**

**(A) a health insurance carrier;**

**(B) a health maintenance organization; or**

**(C) another managed care entity;**

**the degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as the person would use under the same or similar circumstances.**

**Sec. 12. "Person" means an individual, a corporation, a partnership, a limited liability company, an unincorporated association, the state, or a political subdivision (as defined in IC 36-1-2-13).**

**Chapter 2. The Duty of Ordinary Care**

**Sec. 1. This chapter does not apply to worker's compensation insurance coverage under IC 22-3-2 through IC 22-3-6.**

**Sec. 2. A health insurance carrier, a health maintenance organization, or another managed care entity through which a health care plan is operated:**

**(1) has the duty to exercise ordinary care when making health care treatment decisions; and**

**(2) is liable for damages in compensation for harm to an insured or enrollee that is proximately caused by the failure of the health insurance carrier, health maintenance organization, or managed care entity to exercise ordinary care.**

**Sec. 3. A health insurance carrier, a health maintenance organization, or another managed care entity through which a health care plan is operated is liable for damages in compensation for harm to an insured or enrollee proximately caused by a health care treatment decision made by an employee, an agent, an ostensible agent, or a representative of the health insurance carrier, health maintenance organization, or managed care entity if, at the time the decision is made:**

**(1) the employee, agent, ostensible agent, or representative is acting on behalf of the health insurance carrier, health**

**maintenance organization, or other managed care entity; and**

**(2) the health insurance carrier, health maintenance organization, or other managed care entity:**

**(A) has the right to exercise influence or control over the employee, agent, ostensible agent, or representative; or**

**(B) is actually exercising influence or control over the employee, agent, ostensible agent, or representative, resulting in the failure to exercise ordinary care.**

**Sec. 4. In an action brought under section 3 of this chapter that is based on a health care treatment decision allegedly made by an employee, an agent, an ostensible agent, or a representative of a health insurance carrier, a health maintenance organization, or another managed care entity through which a health care plan is operated, it is a defense that:**

**(1) neither:**

**(A) the health insurance carrier, health maintenance organization, or other managed care entity; nor**

**(B) the employee, agent, ostensible agent, or representative for whose conduct the health insurance carrier, health maintenance organization, or other managed care entity is allegedly liable;**

**controlled, influenced, or participated in the health care treatment decision in question; and**

**(2) the health insurance carrier, health maintenance organization, or other managed care entity did not deny or delay payment for any treatment prescribed or recommended by a health care provider to the insured or enrollee in question.**

**Sec. 5. Sections 2 and 3 of this chapter do not obligate a health insurance carrier, a health maintenance organization, or other managed care entity through which a health care plan is operated to provide to an insured or enrollee treatment that is not covered by the health care plan.**

**Sec. 6. A health insurance carrier, a health maintenance organization, or another managed care entity may not:**

**(1) remove a physician or other health care provider from its health care plan; or**

**(2) refuse to renew the status of a physician or other health care provider with the health care plan;**

**for advocating on behalf of an insured or enrollee for appropriate and medically necessary health care for the insured or enrollee.**

**Sec. 7. (a) A health insurance carrier, a health maintenance**

**organization, or another managed care entity may not enter into a contract with a:**

**(1) physician, hospital, or other health care provider; or**

**(2) pharmaceutical company;**

**that includes an indemnification or hold harmless clause applying to the acts or conduct of the health insurance carrier, health maintenance organization, or other managed care entity.**

**(b) An indemnification or hold harmless clause described in subsection (a) is void.**

**Sec. 8. A law prohibiting a health insurance carrier, a health maintenance organization, or another managed care entity from practicing medicine or being licensed to practice medicine may not be asserted as a defense by a health insurance carrier, a health maintenance organization, or another managed care entity in an action brought under this chapter.**

**Sec. 9. In an action against a health insurance carrier, health maintenance organization, or other managed care entity under this chapter, a finding that a physician or another health care provider is an employee, an agent, an ostensible agent, or a representative of the health insurance carrier, health maintenance organization, or other managed care entity may not be based solely on proof that the name of the physician or other health care provider appears in a listing of approved physicians or health care providers made available to insureds or enrollees under a health care plan.**

**Sec. 10. A person who brings an action under this chapter must comply with IC 34-18.**

**Sec. 11. This chapter does not create any liability on the part of:**

**(1) an employer;**

**(2) an employer purchasing group; or**

**(3) a pharmacy that holds a pharmacy permit issued by the Indiana board of pharmacy under IC 25-26-13;**

**that purchases coverage or assumes risk on behalf of its employees.**

SECTION 2. IC 34-18-5-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2. (a) As used in this section, "actuarial program" means a program used or created by the department to determine the actuarial risk posed to the patient compensation fund under IC 34-18-6 (or IC 27-12-6 before its repeal) by a hospital. The program must be:

(1) developed to calculate actuarial risk posed by a hospital, taking into consideration risk management programs used by the hospital;

(2) an efficient and accurate means of calculating a hospital's

malpractice actuarial risk;

(3) publicly identified by the department by July 1 of each year; and

(4) made available to a hospital's malpractice insurance carrier for purposes of calculating the hospital's surcharge under subsection (g).

(b) Beginning July 1, 1999, the amount of the annual surcharge shall be one hundred percent (100%) of the cost to each health care provider for maintenance of financial responsibility. Beginning July 1, 2001, the annual surcharge shall be set by a rule adopted by the commissioner under IC 4-22-2.

(c) The amount of the surcharge shall be determined based upon actuarial principles and actuarial studies and must be adequate for the payment of claims and expenses from the patient's compensation fund.

(d) The surcharge **for a qualified provider other than a:**

**(1) physician licensed under IC 25-22.5; or**

**(2) hospital licensed under IC 16-21;**

may not exceed the actuarial risk posed to the patient's compensation fund under IC 34-18 (or IC 27-12 before its repeal) by **a** qualified ~~providers.~~ **provider other than a physician licensed under IC 25-22.5 or a hospital licensed under IC 16-21**.

(e) There is imposed a minimum annual surcharge of one hundred dollars ($100).

(f) Notwithstanding subsections (b), (c), and (e), beginning July 1, 1999, the surcharge for a qualified provider who is licensed under IC 25-22.5 is calculated as follows:

(1) The commissioner shall contract with an actuary that has experience in calculating the actuarial risks posed by physicians. Not later than July 1 of each year, the actuary shall calculate the median of the premiums paid for malpractice liability policies to the three (3) malpractice insurance carriers in the state that have underwritten the most malpractice insurance policies for all physicians practicing in the same specialty class in Indiana during the previous twelve (12) month period. In calculating the median, the actuary shall consider the:

(A) manual rates of the three (3) leading malpractice insurance carriers in the state; and

(B) aggregate credits or debits to the manual rates given during the previous twelve (12) month period.

(2) After making the calculation described in subdivision (1), the actuary shall establish a uniform surcharge for all licensed physicians practicing in the same specialty class. This surcharge

must be based on a percentage of the median calculated in subdivision (1) for all licensed physicians practicing in the same specialty class under rules adopted by the commissioner under IC 4-22-2. The surcharge:

(A) must be sufficient to cover; and

(B) may not exceed;

the actuarial risk posed to the patient compensation fund under IC 34-18-6 (or IC 27-12-6 before its repeal) by physicians practicing in the specialty class.

(g) Beginning July 1, 1999, the surcharge for a hospital licensed under IC 16-21 that establishes financial responsibility under IC 34-18-4 after June 30, 1999, is established by the department through the use of an actuarial program. At the time financial responsibility is established for the hospital, the hospital shall pay the surcharge amount established for the hospital under this section. The surcharge:

(1) must be sufficient to cover; and

(2) may not exceed;

the actuarial risk posed to the patient compensation fund under IC 34-18-6 by the hospital.

(h) An actuarial program used or developed under subsection (a) shall be treated as a public record under IC 5-14-3.

SECTION 3. [EFFECTIVE JULY 1, 1999] **IC 27-14, as added by this act, applies to causes of action arising after June 30, 1999.**

COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, Corporations and Small Business, to which was referred House Bill 1195, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill do pass.

FRY, Chair

Committee Vote: yeas 9, nays.

HOUSE MOTION

Mr. Speaker: I move that House Bill 1195 be amended to read as follows:

Page 1, line 12, after "organization" insert "**,**".

Page 5, between lines 32 and 33, begin a new paragraph and insert:

"SECTION 2. IC 34-18-5-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2. (a) As used in this section, "actuarial program" means a program used or created by the department to determine the actuarial risk posed to the patient compensation fund under IC 34-18-6 (or IC 27-12-6 before its repeal) by a hospital. The program must be:

(1) developed to calculate actuarial risk posed by a hospital, taking into consideration risk management programs used by the hospital;

(2) an efficient and accurate means of calculating a hospital's malpractice actuarial risk;

(3) publicly identified by the department by July 1 of each year; and

(4) made available to a hospital's malpractice insurance carrier for purposes of calculating the hospital's surcharge under subsection (g).

(b) Beginning July 1, 1999, the amount of the annual surcharge shall be one hundred percent (100%) of the cost to each health care provider for maintenance of financial responsibility. Beginning July 1, 2001, the annual surcharge shall be set by a rule adopted by the commissioner under IC 4-22-2.

(c) The amount of the surcharge shall be determined based upon actuarial principles and actuarial studies and must be adequate for the payment of claims and expenses from the patient's compensation fund.

(d) The surcharge **for a qualified provider other than a:**

**(1) physician licensed under IC 25-22.5; or**

**(2) hospital licensed under IC 16-21;**

may not exceed the actuarial risk posed to the patient's compensation fund under IC 34-18 (or IC 27-12 before its repeal) by **a** qualified ~~providers.~~ **provider other than a physician licensed under IC 25-22.5 or a hospital licensed under IC 16-21.**

(e) There is imposed a minimum annual surcharge of one hundred dollars ($100).

(f) Notwithstanding subsections (b), (c), and (e), beginning July 1, 1999, the surcharge for a qualified provider who is licensed under IC 25-22.5 is calculated as follows:

(1) The commissioner shall contract with an actuary that has

experience in calculating the actuarial risks posed by physicians. Not later than July 1 of each year, the actuary shall calculate the median of the premiums paid for malpractice liability policies to the three (3) malpractice insurance carriers in the state that have underwritten the most malpractice insurance policies for all physicians practicing in the same specialty class in Indiana during the previous twelve (12) month period. In calculating the median, the actuary shall consider the:

(A) manual rates of the three (3) leading malpractice insurance carriers in the state; and

(B) aggregate credits or debits to the manual rates given during the previous twelve (12) month period.

(2) After making the calculation described in subdivision (1), the actuary shall establish a uniform surcharge for all licensed physicians practicing in the same specialty class. This surcharge must be based on a percentage of the median calculated in subdivision (1) for all licensed physicians practicing in the same specialty class under rules adopted by the commissioner under IC 4-22-2. The surcharge:

(A) must be sufficient to cover; and

(B) may not exceed;

the actuarial risk posed to the patient compensation fund under IC 34-18-6 (or IC 27-12-6 before its repeal) by physicians practicing in the specialty class.

(g) Beginning July 1, 1999, the surcharge for a hospital licensed under IC 16-21 that establishes financial responsibility under IC 34-18-4 after June 30, 1999, is established by the department through the use of an actuarial program. At the time financial responsibility is established for the hospital, the hospital shall pay the surcharge amount established for the hospital under this section. The surcharge:

(1) must be sufficient to cover; and

(2) may not exceed;

the actuarial risk posed to the patient compensation fund under IC 34-18-6 by the hospital.

(h) An actuarial program used or developed under subsection (a) shall be treated as a public record under IC 5-14-3.".

Renumber all SECTIONS consecutively.

(Reference is to HB 1195 as printed January 27, 1999.)

FRY